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State/Territory Name: North Dakota

State Plan Amendment (SPA) #: 21-0018

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
601 E. 12th Street, Suite 355
Kansas City, MO 64106

CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

Medicaid & CHIP Operations Group

November 16, 2021

Caprice Knapp, Medicaid Director
Division of Medical Services
North Dakota Department of Human Services
600 East Boulevard Avenue, Dept. 325
Bismarck, ND 58505-0250

RE: North Dakota State Plan Amendment (SPA) 21-0018

Dear Ms. Knapp:

We have reviewed the State Plan Amendment (SPA) submitted under transmittal number 21-0018. This SPA amends the State Plan to renumber Attachment 4.19-B.

Please be informed that this SPA was approved on November 16, 2021, with an effective date of October 1, 2021. Enclosed are the CMS-179 and SPA pages.

Should you have any questions about this amendment, please contact Curtis Volesky at (303) 844-7033.

Sincerely,

[redacted]
Digitally signed by James G. Scott -S
Date: 2021.11.16 15:51:48 -06'00'

James G. Scott, Director
Division of Program Operations

cc: Krista Fremming, krfremming@nd.gov
Stacey Koehly, skoehly@nd.gov
LeeAnn Thiel, lthiel@nd.gov

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE AND MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: CENTERS FOR MEDICARE AND MEDICAID SERVICES	1. TRANSMITTAL NUMBER: **21-0018**	2. STATE **North Dakota**
	3. PROGRAM IDENTIFICATION: **TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)**	
TO: REGIONAL ADMINISTRATOR CENTERS FOR MEDICARE AND MEDICAID SERVICES DEPARTMENT OF HEALTH AND HUMAN SERVICES	4. PROPOSED EFFECTIVE DATE **October 1, 2021**	

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ **NEW STATE PLAN** ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ **AMENDMENT**

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION: **42 CFR 447.201 and 447.302**	7. FEDERAL BUDGET IMPACT: a. FFY **2022** **$0** b. FFY **2023** **$0**
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: **Attachment 4.19-B pages 3, 3c, 4, 5, 6, 7, 7a, and 7b**	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: **Attachment 4.19-B pages 3, 3b-1, 3b-2, 3c, 4, 5, 6, 7, 7a, and 7b (TN No. 21-0006, 18-0011, 19-0001, 13-007, 17-0011, 19-0004, 21-0010, 21-0009 and 18-0024)**

10. SUBJECT OF AMENDMENT:
Amends the State Plan to renumber Attachment 4.19-B.

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
Caprice Knapp, Director
Medical Services Division

12. SIGNATURE OF STATE AGENCY OFFICIAL: [redacted]	16. RETURN TO: **Caprice Knapp, Director** **Medical Services Division** **ND Department of Human Services** **600 East Boulevard Avenue Dept 325** **Bismarck ND 58505-0250**
13. TYPED NAME: **Caprice Knapp**	
14. TITLE: **Director, Medical Services Division**	
15. DATE SUBMITTED: **November 10, 2021**	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: November 10, 2021	18. DATE APPROVED: November 16, 2021
PLAN APPROVED – ONE COPY ATTACHED	
19. EFFECTIVE DATE OF APPROVED MATERIAL: October 1, 2021	20. SIGNATURE OF REGIONAL OFFICIAL: [redacted] Digitally signed by James G. Scott -S ate: 2021.11.16 15:53:59 -06'00'
21. TYPED NAME: James G. Scott	22. TITLE: Director, Division of Program Operations

23. REMARKS:

FORM CMS-179 (07-92)

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPES OF CARE:

18. Covered outpatient drugs submitted on a professional claim form will be reimbursed at the lower of the fee schedule established by the state agency or the estimated acquisition cost for the national drug code as outlined on item 34 on pages 6 and 6a of Attachment 4.19-B.

19. Effective July 1, 2019, for Nurse Practitioner Services, payment will be the lower of billed charges or 75% of the reimbursement under Attachment 4.19-B, Methods and Standards for Establishing Payment Rates – Other Types of Care (continued), item 6, 6a and 6b.

20. Effective July 1, 2019, for Other Practitioner Services, unless otherwise specified, payment will be the lower of billed charges or 75% of the reimbursement under Attachment 4.19-B, Methods and Standards for Establishing Payment Rates – Other Types of Care (continued), item 6, 6a and 6b.

21. Effective July 1, 2019, Registered Nurses who are either employed by or under contract through a school for nursing services provided to Medicaid eligible children (under age 21) who have an approved Individualized Education Program that documents medical necessity for nursing services that support the child's need to access free appropriate public education, payment will be the lower of billed charges or reimbursement under Attachment 4.19-B, Methods and Standards for Establishing Payment Rates – Other Types of Care (continued), item 6, 6a, and 6b.

22. Vacated

23. Personal Care Services

    a. Authorized personal care services provided to an individual who receives personal care services from a provider on less than a 24-hour-a-day-seven-day-a-week basis shall be paid based on a maximum 15-minute unit rate established by the department. Rates will be established for individual and agency providers.

       North Dakota Medicaid providers will receive a 2 percent inflationary increase in reimbursement effective for dates of service on or after July 1, 2021, as authorized and appropriated by the 2021 Legislative Assembly. Providers who travel at least twenty-one miles round-trip to provide personal care services to individuals in rural areas, will receive a rate adjustment effective for dates of service January 1, 2015.

    b. Authorized personal care service provided to an individual by a provider who provides personal care services on a 24-hour-a-day-seven-day-a-week basis shall be paid using a prospective per diem rate for each day personal care services are provided.

       1) The maximum per diem rate for an individual or agency provider shall be established using the provider's allowable hourly rate established under paragraph a. multiplied times the number of hours per month authorized in the individual's care plan times twelve and divided by 365. The provider may bill only for days in which at least 15 minutes of personal care service are provided to the individual. The maximum per diem rate for an individual or agency may not exceed the maximum per diem rate for a residential provider as established in subparagraph 2.

31. **Payments to Indian Health Services and Tribal 638 Programs**

All-inclusive rates (AIR): The Medicaid all-inclusive rates (AIR) are published each year in the Federal Register by the Department of Health and Human Services, for general covered services provided by Indian Health Services (IHS) facilities and facilities operated by federally recognized tribes under P.L. 93-638.

The general covered service categories are: Inpatient; Outpatient, Pharmacy, Vision, Dental, Mental Health, Substance Use Disorder, Clinic and EPSDT.

Tribal 638 Federally Qualified Health Center (FQHC) Alternate Payment Methodology
A tribal health program selecting to enroll as a FQHC and agreeing to an alternate payment methodology (APM) will be paid using the APM, which is the AIR. Tribal 638 FQHCs are not required to comply with the HRSA rules for a FQHC.

North Dakota Medicaid will establish a Prospective Payment System (PPS) methodology for Tribal 638 FQHCs. The PPS rate shall be the average rate of other FQHCs in the state. Annually, North Dakota Medicaid will compare the APM rate to the PPS rates to ensure the APM is equal to or greater than the PPS rate. The Tribal 638 FQHCs are not required to report its costs for the purposes of establishing a PPS rate.

Multiple visits for different services on the same day with different diagnosis:
IHS facilities, Tribal 638 facilities, and Tribal 638 FQHCs are eligible for multiple encounter payments for general covered service categories on the same day for the same recipient with a different diagnosis. A pharmacy service is one encounter payment regardless of how many prescriptions are filled on that day.

Multiple visits for different services on the same day with the same diagnosis:
IHS facilities, Tribal 638 facilities, and Tribal FQHCs are eligible for multiple encounter payments for general covered service categories on the same day for the same recipient with the same diagnosis provided they are for distinctly different services. The diagnosis code may be the same for each of the encounters, but the services provided must be distinctly different and occur within different units of the facility.

Multiple visits for the same type of service on the same day with different diagnoses:
IHS facilities, Tribal 638 facilities, and Tribal 638 FQHCs are eligible for multiple encounter payments for multiple same day visits for the same type of general covered service category if the diagnoses are different.

32. The payment methodology for Rural Health Clinics (RHC) shall conform to section 702 of the Benefits Improvement and Protection Act (BIPA) of 2000. A RHC that agrees in writing to the use of an alternative payment methodology shall be reimbursed using an alternative payment methodology (APM) identified in subsection B of this section. A RHC which does not agree to the state's alternative payment methodology shall be reimbursed on a prospective payment system (PPS) identified in subsection A of this section. On an annual basis the state will compare the APM rate established to the PPS rate to ensure that the APM rate is at least equal to the PPS rate.

    RHC Services are defined as those services that are reimbursable in 42 CFR 405.2411.

A. Prospective Payment System (PPS) Rate

    1. Establishment of PPS Rate

        A RHC shall be reimbursed on a prospective payment system for services furnished on or after January 1, 2001 using a payment rate based on the RHC's reasonable costs for the RHC's fiscal years 1999 and 2000. Reasonable costs are costs which are related to furnishing services and do not exceed billed charges, except for costs related to laboratory services which may not exceed the Medicare fee schedule. Reasonable costs for each year are divided by the number of visits for the year and the PPS rate will be the average of the rates for the two years. The PPS rate shall be effective January 1, 2001. The PPS rate will be adjusted on January 1 of each year by the Medicare Economic Index (MEI) for primary care services and will be adjusted for any increase or decrease in the scope of services furnished by the center during the center's previous fiscal year.

    2. Rate Setting for New RHCs

        In any case in which an entity first qualifies as a RHC after January 1, 2000, the PPS rate for the first year in which services are provided, beginning on or after January 1, 2001 shall be the average rate of the 10 centers located in closest proximity to the RHC. For subsequent calendar years the PPS rate as established shall be adjusted by the MEI.

    3. Upon the RHC's application, the PPS rate shall be adjusted to reflect any increase or decrease in the scope of services furnished by the RHC.

B. Alternative Payment Methodology (APM) Rate

33. The payment methodology for Federally Qualified Health Clinics (FQHCs) shall conform to section 702 of the Benefits Improvement and Protection Act (BIPA) of 2000. A center that agrees in writing to the use of an alternative payment methodology shall be reimbursed using an alternative payment methodology (APM) identified in subsection B of this section. A center which does not agree to the state's alternative payment methodology shall be reimbursed on a prospective payment system (PPS) identified in subsection A of this section. On an annual basis the state will compare the APM rate established to the PPS rate to ensure that the APM rate is at least equal to the PPS rate. At any time the APM rate is less than the PPS rate, a supplemental payment equal to the difference between the APM rate and the PPS rate times the number of visits shall be made quarterly.

A. Prospective Payment System (PPS) Rate

A center shall be reimbursed using a prospective payment system for services furnished on or after January 1, 2001 using a payment rate based on the center's reasonable costs for the center's fiscal years 1999 and 2000. Reasonable costs for each year are divided by the number of visits for the year and the PPS rate will be the average of the rates for the two years. The PPS rate shall be effective January 1, 2001 and will be adjusted on January 1 of each year by the Medicare Economic Index (MEI).

When an entity first qualifies as a FQHC after January 1, 2003 the rate for the first year, or partial year thereof, in which services are first provided shall be the Medicaid interim rate. In accordance with Section 1902(bb)(4) of the Social Security Act, the Medicaid interim rate shall be the amount that is equal to the PPS or APM rate during the most recent calendar year for other FQHCs with similar services and caseloads located in the state. For purposes of this section, a "new FQHC" is an FQHC that meets all applicable licensing or enrollment requirements, and qualifies as an FQHC on or after January 1, 2003. Sites of an existing FQHC that are newly recognized by the Health Resources and Services Administration (HRSA) are not new FQHCs. The rate established shall not be subject to settlement. Beginning January 1 of the year following the year an entity first qualifies as an FQHC, the previous year's Medicaid interim rate shall be adjusted by the MEI. Beginning January 1 of the second year following the year an entity first qualifies as an FQHC a PPS rate shall be established based on the FQHC's Medicare cost report for the first full year of operation.

Upon the FQHC's application, the PPS rate shall be adjusted to reflect any increase or decrease in the scope of services furnished by the FQHC.

B. Alternative Payment Methodology (APM) Rates

Two APM rates shall be established for each FQHC: one rate for medical and other services (i.e., all Medicaid-covered services other than dental services); and one rate for dental services (the "dental APM rate"). These APM rates are fixed rates and are not subject to adjustment or reconciliation except as provided for below.

The FQHC's medical and dental APM rates shall be established according to a two-step process, as follows:

34. For prescribed drugs, including specific North Dakota Medicaid covered non-legend drugs that are prescribed by an authorized prescriber and legend drugs prescribed by an authorized prescriber, North Dakota Medicaid will reimburse at the following lesser of methodology (in all instances, the professional dispensing fee will be $12.46):

    1. The usual and customary charge to the public, or
    2. North Dakota Medicaid's established Maximum Allowable Cost (MAC) for that drug plus the professional dispensing fee (ND Medicaid's MAC is acquisition cost based and includes all types of medications, including specialty and hemophilia products), or
    3. The current National Average Drug Acquisition Cost (NADAC) for that drug plus the professional dispensing fee, or if there is no NADAC for a drug, the current wholesale acquisition cost (WAC) of that drug plus the professional dispensing fee; In compliance with 42 Code of Federal Regulations (C.F.R.) 447.512 and 447.514, reimbursement for drugs subject to Federal Upper Limits (FULs) may not exceed FULs in the aggregate.
    4. For 340B purchased drugs, the lesser of logic will include the 340B MAC pricing (ceiling price) plus the professional dispensing fee.
        a. Covered entities as described in section 1927 (a)(5)(B) of the Social Security Act are required to bill no more than their actual acquisition cost plus the professional dispensing fee.
        b. Drugs acquired through the federal 340B drug pricing program and dispensed by 340B contract pharmacies are not covered, unless the State approves an exception.
    5. All Indian Health Service, tribal and urban Indian pharmacies are paid the encounter rate by ND Medicaid regardless of their method of purchasing.
    6. For Federal Supply Schedule purchased drugs, their provider agreements will require them to bill at no more than their actual acquisition cost plus the professional dispensing fee.
    7. Drugs not distributed by a retail community pharmacy (such as a long-term care facility) will be reimbursed as outlined in items 1-6 above and 8-13 below in this section.
    8. Drugs not distributed by a retail community pharmacy and distributed primarily through the mail (such as specialty drugs) will be reimbursed as outlined in items 1-7 above and 9-13 below in this section since ND Medicaid's MAC is acquisition cost based and includes all types of drugs.
    9. Clotting factors from Specialty Pharmacy, Hemophilia Treatment Centers (HTC), Center of Excellence will be reimbursed as outlined in items 1-8 above and 10-13 below in this section since ND Medicaid's MAC is acquisition cost based and includes all types of drugs.

35. *EPSDT Services*

For medically necessary services not otherwise identified in the State Plan* but available to EPSDT participants, reimbursement shall be the lower of submitted charges or the fee schedule as determined by the State Agency.

As authorized by the 2021 Legislative Assembly, North Dakota Medicaid providers will receive a 2 percent inflationary increase in reimbursement as of July 1, 2021 and is effective for services provided on or after that date. The agency's fee schedule rate for services covered under this section of the plan will be set as of July 1, 2021 and are effective for services provided on or after that date.

*Services not identified under 1905(a) of the Social Security Act are not reimbursed under this authority.

36. For Targeted Case Management Services for individuals with a serious mental illness or serious emotional disturbance, payment will be based on the lower of the provider's actual billed charge or the fee schedule established in 15-minute increments.
a. Payment to state government providers will be based on the cost of delivery of the services on a prospective basis as determined by the single state agency from cost data submitted annually by state government providers. Allowable costs will be determined in accordance with the Medicare Provider Reimbursement Manual. State government provider rates are set as of July 1, 2021 and are effective for services provided on or after that date. Providers will be notified of the rates, via letter and/or email correspondence.
b. As authorized by the 2021 Legislative Assembly, North Dakota Medicaid providers will receive a 2 percent inflationary increase in reimbursement as of July 1, 2021 and is effective for services provided on or after that date. The agency's fee schedule for non-state government providers and private providers will be set as of July 1, 2021 and is effective for services on or after that date.

37. For Targeted Case Management Services for individuals served in the child welfare system, payment will be based on the lower of the provider's actual billed charge or the fee schedule established in 15-minute increments. As authorized by the 2021 Legislative Assembly, North Dakota Medicaid providers will receive a 2 percent inflationary increase in reimbursement as of July 1, 2021 and is effective for services provided on or after that date. The agency's fee schedule rate will be set as of July 1, 2021 and is effective for services on or after that date.

38. For Targeted Case Management Services for Individuals needing Long Term Care services, payment will be based on the lower of the provider's actual billed charge or the fee schedule established in monthly increments. As authorized by the 2021 Legislative Assembly, North Dakota Medicaid providers will receive a 2 percent inflationary increase in reimbursement as of July 1, 2021 and is effective for services provided on or after that date. The agency's fee schedule rate will be set as of July 1, 2021 and is effective for services provided on or after that date.

39. For Targeted Case Management Services for Pregnant women and infants, payment will be based on the lower of the provider's actual billed charge or the fee schedule established per the procedure code definition. As authorized by the 2021 Legislative Assembly, North Dakota Medicaid providers will receive a 2 percent inflationary increase in reimbursement as of July 1, 2021 and is effective for services provided on or after that date. The agency's fee schedule rate will be set as of July 1, 2021 and is effective for services provided on or after that date.

40. Payment for vaccines outside of the Vaccines for Children program will be based on the Average Sales Price (ASP) + 6% as of August 1 each year. If ASP + 6% is not available, then vaccines will be reimbursed at the Wholesale Acquisition Cost from the ND Medicaid vendor for HCPC to NDC crosswalk available as of August 1 of each year. Payment for vaccine administration is based on the rates approved on page 66(b) of the State Plan.